



**CHEYENNE MEDICAL SPECIALIST, P.C.**  
**5050 POWDERHOUSE RD**  
**CHEYENNE, WY 82009**  
**(307) 634-1311 PHONE**  
**(307) 432-7546 FAX**

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

**Full Name of Patient:** \_\_\_\_\_

**Maiden Name/Alias:** \_\_\_\_\_ **Daytime phone:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

<p><b>INFORMATION REQUESTED (X):</b>      ( ) Entire Medical Record</p> <p><i>NOTE: If only a portion of the medical record is requested please specify below:</i></p> <p>( ) Office notes _____ ( ) Laboratory reports _____</p> <p>( ) Procedure reports _____ ( ) X-ray reports/films _____</p> <p>( ) Other _____</p> <p>Identify date of service or date ranges requested including month and year _____</p>
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It is further understood that other records may exist on file for which our office services were contracted by outside sources. **THIS INFORMATION CANNOT BE RELEASED BY CMS.** You must contact that contracted agency, entity or firm to retrieve these records.

**I Authorize CMS or:**

\_\_\_\_\_  
 Name of physician/provider

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City, State, Zip

**To Release my Medical Records to:**

\_\_\_\_\_  
 Name of Individuals receiving information

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City, State, Zip

Alcohol, Drug, Infectious and Psychiatric records are protected by Federal Regulation 42CFR, Part II, and release of these records require specific consent. This authorization covers ALL physician records and information and provides specific consent necessary for the release of the following: Drug or Alcohol Abuse, Infectious Disease (including HIV/AIDS), and Psychiatric problems or issues otherwise specified:

**THE ABOVE RECORD IS REQUESTED FOR THE FOLLOWING REASONS (X):**

- |                            |                        |
|----------------------------|------------------------|
| ( ) Continued Medical Care | ( ) Personal Interest  |
| ( ) Legal Purposes         | ( ) Insurance Purposes |
| ( ) Other _____            |                        |

**NOTE: A PICTURE ID MUST BE PRESENTED WITH THIS AUTHORIZATION FORM. This authorization for disclosure of information will expire ONE YEAR from the date signed. This authorization is subject to revocation at anytime by written notification only. A \$40.00 prepaid fee will be charged if records are requested for personal reasons or to be sent to a third party. However, no fee will be charged if records are sent directly to another continuing care provider. Records may take up to two weeks for completion.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Patient or Legally Authorized Representative

**Relationship to Patient:** \_\_\_\_\_ **Phone Number** \_\_\_\_\_